Delaware Public Health Laboratory
30 Sunnyside Road
Smyrna, DE 19977
Phone: (302) 223-1520 • Fax: (302) 653-2877

Affix CT/GC DNA
Barcode Label Here

MCI#: _____ **Agency Name:** _____ **Collection Date:** _____

Name: (Print Clearly)

(Last) (First)

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Birth Date:** _____

(Check all that apply):

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ White
☐ Native Hawaiian or Pacific Islander ☐ Other Race

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Gender: ☐ Female ☐ Male

Reason for Test: ☐ Screening ☐ Annual
☐ STD Symptoms ☐ Suspected STD contact
☐ Known STD contact ☐ Other

Clinician (Name and ID#): _____ **ICD-9:** _____

Insurance Status: ☐ Private ☐ Medicaid-Delaware Physician's Care, Inc. ☐ Medicaid-Diamond State
☐ Medicaid-Fee for Service ☐ Uninsured ☐ Unknown ☐ Medicaid # _____

TEST REQUESTED

Microbiology

- ☐ Chlamydia and GC DNA Amplification: Cx / Urethra / Urine
- ☐ Syphilis – RPR
- ☐ Syphilis – Confirmatory TPPA (includes RPR)
- ☐ Syphilis – FTA (Sent Out)
- ☐ Syphilis – VDRL (CSF Only)
- ☐ Gonorrhea Culture – Source: _____
- ☐ Urine Culture
- ☐ Throat for Strep Only
- ☐ Bacterial Culture (Misc., wound, genital, respiratory)
  Source: _____
- ☐ Stool Culture
- ☐ Stool Culture to Rule Out Salmonella / Shigella
- ☐ Ova and Parasites
- ☐ Serotype Organism: _____ Source: _____
- ☐ AFB Culture and Smear Source: _____
- ☐ AFB Smear Only Source: _____

Virology

- ☐ Viral Culture Source: _____
- ☐ HIV Source: _____
- ☐ Influenza Culture Source: _____
- ☐ RMK Isolate Source: _____
- ☐ Chlamydia Culture Source: _____
- ☐ CSF Culture Profile
- ☐ WNV IgG
- ☐ WNV IgM
- ☐ Hepatitis A Antibody IgM and IgG
- ☐ Hepatitis B Surface and Core Antigens
- ☐ Hepatitis B Surface Antibody
- ☐ Serology (list below) Acute or Convalescent (circle)
  Date Drawn: _____

_____
_____
_____

Rapid / Clinic Tests

- ☐ Stat RPR
- ☐ GC Gram Stain (males only)

Chemistry

- ☐ Blood Lead

GONORRHEA / CHLAMYDIA DNA AMPLIFICATION QUESTIONS FOR YOUTH THROUGH AGE 18

#Sexual partners during past 6 months?	_____	
Had STD education in school?	Yes	No
Past history Syphilis?	Yes	No
Past history Chlamydia?	Yes	No
Past history Gonorrhea?	Yes	No
Past history other STD?	Yes	No
Females-history of previous PID?	Yes	No
Females-previous pregnancy?	Yes	No
Under influence of drugs or alcohol during last sexual encounter?	Yes	No
Used a condom last sexual encounter?	Yes	No

Check Contraceptive Method Used in Last Sexual Encounter:

- ☐ Abstinence
- ☐ Condom
- ☐ Condom and Spermicides
- ☐ Diaphragm
- ☐ Injectable contraceptive
- ☐ IUD
- ☐ Oral Contraceptive
- ☐ Spermicides
- ☐ No Method
- ☐ Other _____

Manual test requisition form updated 2/1/06.